5. Third Party Coverage

Contents

5.1 About Medicaid and Medicare

In 1965, the Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW).

In 1977, the Health Care Financing Administration (HCFA) was created in HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

5.2 Medicaid

Medicaid (Title XIX of the Federal Social Security Act) is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program became law in 1965 and is jointly funded by Federal and State governments (including the District of Columbia and the Territories) to assist states in providing medical and long-term care assistance to people who meet certain eligibility criteria Medicaid is the largest source of funding for medical and health-related services for people with limited income.

For a description of eligibility criteria, see Part 2, Chapter 7, Section 7.5, “Medicaid Eligibility and Application.”

The Federal statue identifies over 25 different eligibility categories for which federal funds are available; however, each state has its own plan and all 23 eligibility categories may not be utilized. These statutory categories can be classified into five broad coverage groups: children, pregnant women, adults in families with dependent children, individuals with disabilities, and individuals 65 or over.

Utilizing broad national guidelines, each state has the right to establish its own eligibility standard; determine the type, amount, duration, and scope of services; set the rate of payment for services; and administer the program. Thus, Medicaid guidelines vary from state to state. Currently, 37 states have medically needy programs.

All states provide community Long Term Care services for individuals who are Medicaid eligible and qualify for institutional care.

All state plans must be approved by CMS prior to adoption. State plans include how IHS and Tribal facilities are reimbursed.

5.2.1 Covered Medicaid Benefits

Most Medicaid programs pay for medically necessary health services furnished by medical providers who participate in Medicaid. Medicaid covers a range of medical services, including traditional acute care services, transportation, physician services, home health care, durable medical equipment, and medical supplies. Medicaid also covers services which are medically necessary for the diagnosis and/or treatment of illnesses, injuries, or conditions of recipients.

The following services are typically covered by Medicaid:

- Inpatient hospital (excluding inpatient services in institutions for mental disease)
- Outpatient hospital including Federally Qualified Health Centers (FQHCs), and if permitted under state law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under states' plans.
- Other laboratory and x-ray services
- Certified pediatric and family nurse licensed practitioners
- Nursing facility services for beneficiaries, age 21 and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- Family planning services and supplies
- Physicians' services
- Medical and surgical services of a dentist
- Home health services, including
  - Intermittent or part-time nursing services
  - Home health aides
  - Medical supplies and appliances for use in the home
- Nurse mid-wife services

- Pregnancy related services and services for other conditions that might complicate pregnancy
- 60 days postpartum pregnancy-related services

5.2.2 Examples of Non-covered Medicaid Services

Note: This is a representative list of non-covered services. Each facility or clinic needs to check with their State Medicaid office to verify what services are covered or not covered in their particular state.

- Broken or missed appointments
- Services furnished by contractors, organizations, or individuals which are not the billing provider
- Cosmetic services and surgeries prescribed or used for aesthetic purposes only
- Dental services performed for aesthetic or cosmetic purposes only
- Separate charges for kits, films, supplies, or other material used in the performance of diagnostic imaging or therapeutic radiology services
- Durable medical equipment and medical supplies that are not primarily and customarily for a therapeutic purpose and are generally used for comfort or convenience purposes
- Literature, booklets, and other educational materials
- Experimental or investigational services
- Routine foot care, such as removal of corns or calluses
- Hair or nail analysis
- Laboratory specimen handling, mailing, or collection fees
- Methadone drug treatment
- Post-mortem examinations
- Pregnancy termination
- Oral, topical, optic, or ophthalmic preparations dispensed to recipients by the clinic
- Services by providers not covered by Medicaid
- Reproductive health services
- Visits to pick up prescriptions or telephone consultations
- Routine physical examinations
- Screening services that are not used to make a diagnosis
- Vision eyewear
- Hearing aids

- Homeopathic therapy
- Chiropractic services
- Acupuncture used for medical management of acute or chronic pain, or as an anesthetic
- Services not covered by Medicare

5.2.3 State Children's Health Insurance Program (SCHIP)

As part of the Balanced Budget Act of 1997, Congress created Title XXI, the State Children's Health Insurance Program (SCHIP) to address the growing problem of children without health insurance. SCHIP was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children up to age 19, whose families earn too much money to be eligible for Medicaid but not enough money to purchase private insurance. SCHIP is the single largest expansion of health insurance coverage for children since the initiation of Medicaid in the mid-1960s.

SCHIP is designed to provide coverage to "targeted low-income children". A "targeted low-income child" is one who resides in a family with income below 200% of the Federal Poverty level (FPL) or whose family has an income 50% higher than the state's Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families, not just the children.

Ineligible children are those children who are

- covered under a group health plan or under health insurance coverage.
- members of a family that is eligible for state employee insurance based on employment with a public agency.
- residing in an Institution for Mental Disease.
- eligible for Medicaid coverage.

SCHIP offers three options:

1) Use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program.

2) Design a separate children's health insurance program entirely separate from Medicaid.

3) Combine both the Medicaid and separate program options.

If a state elects to establish an expanded Medicaid program using SCHIP, the eligibility rules of Medicaid apply and the services provided mirror the Medicaid services of that state. For a separate child health program, the states have the option of determining the level of coverage.

5.2.4 Medicaid Managed Care

Currently, 48 states offer some form of managed care. Since 1992, states have utilized federal Medicaid waivers to increase enrollment in managed care and to develop other innovative changes to their Medicaid programs. Several states have used the resulting savings from managed care enrollment to expand the number of individuals covered by Medicaid and/or the number of services covered under their programs.

States may also apply for waivers of Medicaid rules to test innovative approaches to benefits, services, eligibility, program payments, and service delivery. State demonstration projects are frequently aimed at saving money to allow states to extend Medicaid coverage to additional low-income and uninsured people.

Since January 1993, comprehensive health care reform demonstration waivers have been approved for 18 states. In addition, HHS has approved requests from 19 states for Medicaid waivers as part of larger welfare reform projects, as well as 25 local Medicaid demonstration projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.

The Medicaid Managed Care program allows the States greater flexibility to amend their State plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without obtaining waivers.

For more information on Medicaid Managed Care, go to this website:

http://www.cms.hhs.gov/MedicaidManagCare/

5.3 Medicare

Medicare is a national health care program covering

- individuals 65 and older,
- individuals under 65 who are disabled, and
- individuals with end stage renal disease (ESRD).

Medicare, like Medicaid, pays for medically necessary health services furnished by medical providers.

The Indian Health Service authorizes private physicians and privately owned hospitals and nursing homes to provide treatment to Indians and their dependents under contractual arrangements with the Division of Indian Health. Contract health services via Contract Health Services (CHS) are provided when IHS facilities and clinics either do not offer the level of care or the specialty service.

When CHS providers or facilities are used, Medicare is the primary payor and IHS is secondary payor.

5.4 Medicare Part A

Medicare Part A (Title XVIII of the Social Security Act) is the hospital insurance that pays for inpatient hospital services, skilled nursing facility services, home health care, and hospice care.

Most individuals become entitled to Medicare Part A when they reach the age of 65 and are also eligible for monthly social security retirement or survivor benefits or railroad retirement benefits. Individuals age 65 or over who are not entitled to Part A because they do not meet these conditions, may enroll in the Part A program if they pay a monthly premium.

Medicare Part A is also available to individuals under age 65 if they are entitled to (1) social security or railroad retirement disability benefits, or (2) have end-stage renal disease.

The Fiscal Intermediary (FI) for IHS is Trailblazers. Tribes have the option of using Trailblazers or another FI, such as Federally Qualified Health Center (FQHC), Rural Health Center, or billing the local Medicare Part B.

5.4.1 Covered Benefits, Medicare Part A

Inpatient Medicare (Part A) covers the following services furnished to an inpatient of a participating hospital or, in case of emergency services, to an inpatient of a qualified hospital:

- Medicare Part A inpatient services are paid based on Diagnosis Related Groups (DRGs).
- Room and Board – A semi-private room or a private room (if medically necessary), and the Intensive Care Unit (ICU) if the level of care requires this type of patient services
- Nursing services and other related services
- Use of hospital facility
- Operating room charges
- Drugs furnished by the hospital
- Laboratory tests
- X-ray and other radiology services
- Medical supplies, such as casts and splints
- Use of appliances and equipment furnished by the hospital, such as wheelchairs, crutches, canes, etc.
- Physical, speech, or occupational therapy
- Medical social services
- Respiratory Therapy
- Inpatient hospital stays for rehabilitation care
- Inpatient psychiatric hospital services
- Observation room
- Emergency room
- Transportation services, including transport by ambulance

5.4.2 Non Covered Services, Medicare Part A

Inpatient Medicare hospital Part A services *do not cover*:

- Post-hospital Skilled Nursing care furnished by a hospital, or a critical access hospital that has a swing-bed approval
- Nursing facility services that may be furnished as a Medicaid service in a swing-bed hospital has an approval to furnish nursing facility services
- Physician services that meet the requirements for payment on a fee scheduled basis
- Physician assistant services

- Nurse practitioner and clinical nurse specialist services
- Certified nurse mid-wife services
- Qualified psychologist

The beneficiary is responsible for a cash deductible for each benefit period and a coinsurance amount that equals one-quarter of the inpatient deductible amount from the 61st to the 90th day of an inpatient admission. The beneficiary may also elect to use the 60 lifetime reserve days with a coinsurance amount that equals one-half of the inpatient deductible.

5.4.3 Lifetime Reserve Days

Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services available after he/she has used 90 days (60 full and 30 coinsurance) of inpatient hospital services in a spell of illness. Depending on the situation, the patient may elect not to use his lifetime reserve days.

Such situations would include:

- The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days; *and*
  - The hospital is reimbursed on a cost reimbursement basis;
    or
  - The hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days.
- For the non-outlier portion of a stay in a hospital reimbursed under the prospective payment system, if the beneficiary has one or more regular (non-lifetime reserve) days remaining in the benefit period upon admission to the hospital.
- The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the prospective payment system and the total charges for which the beneficiary would be liable if he/she does not use lifetime reserve days are equal to or less than the sum of the coinsurance amounts of the lifetime reserve days needed for the stay.

Note: For hospital reimbursed under the prospective payment system, if a patient has one or more regular benefits (non-lifetime reserve, i.e., coinsurance days) days remaining in the benefit period upon entering the hospital, Medicare will pay the entire PPS amount of the non-outlier days. Therefore, it would not benefit the patient to utilize his lifetime reserve days.

For patients utilizing 25 coinsurance days and who remain in the hospital over the 30-day coinsurance threshold and enter into lifetime reserve days, the hospital must inform the patient. It is the patient's decision on electing to use the lifetime reserve days.

A retroactive election not to use the lifetime reserve days must be filed within 90 days following the beneficiary's discharge from the hospital, unless benefits are available from a third-party payor to pay for the services, and the hospital agrees to the retroactive election. In those cases, the beneficiary may file an election not to use the lifetime reserve days later than 90 days following discharge.

5.4.4 Benefit Period

The term **benefit period** is defined as the period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient can be paid for by the hospital insurance plan.

The **first day of the benefit period** is when a patient is furnished inpatient hospital or skilled nursing facility services by an approved provider after entitlement to hospital insurance begins. From the date of discharge from any inpatient or swing-bed stay, the time will begin to accrue for the first day of a new benefit period. A transfer from one hospital to another is not considered a discharge, even if the transfer is considered a discharge under PPS. Also, a leave of absence is not considered a discharge from the hospital.

The **end of the benefit period** is when a beneficiary has not been an inpatient of a hospital or a swing-bed facility for sixty (60) consecutive days. At this time, the benefits will be renewed for full and coinsurance days only.

To calculate the sixty (60) consecutive days, begin counting with the day the individual was discharged. A benefit period cannot end while a beneficiary is an inpatient of a skilled nursing facility (SNF) where the SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Examples of Benefit Period:

Example 1: Mrs. Smith enters the hospital on July 5 and is discharged on July 15. In this example, Mrs. Smith has used 10 days of her first benefit period. Mrs. Smith is not hospitalized until again until December 15. Since more than sixty days elapsed between her hospital days, she begins a **new** benefit period and will be obligated to pay the hospital deductible.

Example 2: Mrs. Smith enters the hospital on August 14 and is discharged on August 24. Like the first example, Mrs. Smith has used 10 days of her first benefit period. However, Mrs. Smith is readmitted to the hospital on September 20. Since fewer than sixty days have elapsed between hospital days, Mrs. Smith is still in her fist benefit period and will not be required to pay another deductible. In essence, the admission on September 20 is actually the eleventh day used in her first benefit period. Mrs. Smith will not begin a new benefit period until she is out of the hospital and/or SNF for more than sixty consecutive days.

5.5 Medicare Part B

Medicare Part B is a voluntary program and provides the medical insurance that covers doctor's services, outpatient hospital services, durable medical equipment, and medical services and supplies not covered under Part A. The program is financed from premium payments by the enrollees or by states under the Medicaid program.

Because Medicare Part B is separate and distinct from Medicare Part A, it is possible for a person to enroll without being entitled to monthly social security or railroad retirement benefits or even receive Part A benefits.

For a provider to be paid under Medicare, the provider must voluntarily participate with Medicare via a written agreement and accept assignment, and the level of care received by the patient must be medically necessary. Assignment means that the provider agrees to accept the Medicare approved amount for each services as payment in full. If the provider does not want to participate, he must revoke his agreement in writing to all carriers with whom he/she has filed an agreement.

Most of Medicare Part B physician services are paid based on a physician fee schedule. There is an annual deductible and a 20% coinsurance for covered medical expenses. However, Indian health Service providers do not collect this amount from the American Indian/Alaskan Native beneficiaries.

For emergency situations, the patient may be seen in a non-participating hospital.

5.5.1 Covered Services, Medicare Part B

Examples of covered services under Part B include:

- Physician's services, including surgery, consultation, office and institutional calls, and services and supplies furnished incident to a physician's professional service
- Physician's services are paid based on Part B fee schedule.
- Outpatient hospital services furnished incident to physicians' services
- Outpatient diagnostic services furnished by a hospital/clinic
- Outpatient physical therapy, outpatient occupational therapy, outpatient speech-language pathology services (clinic based only)
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests
- X-ray, radium and radioactive isotope therapy
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations
- Rental or purchase of durable medical equipment in the home
- Ambulance service
- Prosthetic devices, other than dental, which replace all or part of an internal body organ
- Leg, arm, back and neck braces, and artificial legs, arms, and eyes; includes adjustments, repairs, and replacements
- Certain medical supplies used in connection with home dialysis delivery systems
- Rural Health Clinic (RHC) services

- Ambulatory surgical center (ASC) services
- Screening mammography services
- Screening pap smears and pelvic exams
- Screening glaucoma services
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Colorectal screening
- Bone mass measurements
- Diabetes self-management services
- Prostrate screening
- Home health visits after all covered Part A visits have been used

5.5.2 Non-covered Services, Medicare Part B

Examples of non-covered Medicare Part B services are:

- Services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Routine foot care in general is excluded, except some particular foot care is covered.
- Items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This would include services furnished gratuitously or provided free.
- Some providers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation because it is clear that a patient would be charged if insured, a legal obligation to pay exists and benefits are payable for services rendered to patients with medical insurance, if the provider customarily bills all insured patients – not just Medicare patients – even though non-insured patients are not charged.
- Other primary insurance to Medicare
- Items and services furnished, paid, or authorized by Federal, State, or Local government entities
- Services resulting from war
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member

- Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations (unless for the latter the immunization relates to the treatment of any injury or direct exposure to a disease)
- Custodial care
- Cosmetic surgery that is related to improving appearance
- Charges of immediate relatives of the patient
- Dental services that include care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

5.5.3 Services "Incident to" Diagnosis or Treatment

Services such as lab and x-ray and other services can be paid to IHS under the "incident to" interpretation of Medicare Part B reimbursement. This is interpreted as being integral and part of the provider's professional services in the course of diagnosing or treating the patient's illness or injury. The orders must be written by the provider and needs to be under the auspice and direction or the provider. For the latter, this is interpreted as "the provider has ordered the test, is available at the clinic for discussion, and will review the results". It is also interpreted as "the provider may issue standing orders for the nurse in that the nurse can order the tests and the provider will review the result."

5.6 Medicare/Medicaid Dual Eligibles

Medicare provides two basic coverages:

- Part A, which pays for hospitalization costs
- Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services

Dual eligibles are those individuals who are entitled to Medicare Part A *and/or* Part B, *and* are eligible for some form of Medicaid benefit.

Note: For the most current information, please go to this website: http://www.cms.hhs.gov/DualEligible/

These are the various categories of individuals, who collectively are known as **dual eligibles**

- **Qualified Medicare Beneficiary (QMB) without other Medicaid (QMB only)**
  - Entitled to Medicare Part A
  - Income of 100% Federal poverty level (FPL) or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for full Medicaid

  Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

- **QMB with full Medicaid (QMB plus)**
  - Entitled to Medicare Part A
  - Income of 100% FPL or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Eligible for Medicaid benefits

  Medicaid pays their Medicare Part A premiums, if any; Medicare Part B premiums; and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

- **Specified Low-Income Medicare Beneficiary (SLMB) without other Medicaid (SLMB Only)**
  - Entitled to Medicare Part A
  - Income greater than 100% but less than 120% FPL
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for Medicaid

  Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

- **SLMB with full Medicaid (SLMB Plus)**
  - Entitled to Medicare Part A
  - Income greater than 100% but less than 120% PPL
  - Resources do not in exceed twice the limit for SSI eligibility
  - Eligible for full Medicaid benefits

  Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

- **Qualified Disabled and Working Individual (QDWI)**
  - Lost Medicare Part A benefits due to returning to work, but eligible to enroll in and purchase Medicare part A
  - Income of 200% FPL or less
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for Medicaid.

  Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100%.

- **Qualifying Individual (2) (QI-1)**

  This group is effective 1/1/98-12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group.
  - Entitled to Medicare Part A
  - Income of at least 135% but less than 175% FPL
  - Resources do not exceed twice the limit for SSI eligibility
  - Not otherwise eligible for Medicaid.

  Medicaid pays only a portion of their Part B premiums. FFP equals FMAP at 100%.

- **Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1)**

  Typically, these individuals need to spend down to qualify for Medicaid or to fall into a Medicaid eligibility poverty group that exceeds the limits listed.
  - Entitled to Medicare Part A and/or Part B
  - Eligible for full Medicaid benefits
  - Not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1

  Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability.

  Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

5.7 Medicare Advantage, Part C

The Medicare Advantage program replaced the Medicare+Choice (M+C) program under Medicare Part C. Under this program, Medicare pays a set amount of money for a Medicare patient's care every month to a private health plan that manages Medicare coverage for its members. In most Medicare Advantage Coordinated Care plans, there are doctors and hospitals that join the plan, called the plan's network. Most of the care required is obtained from the doctors within the network, and referrals are required for services outside of the network.

5.7.1 Medicare Advantage Prescription Drug Plan (MA-PD)

Individuals enrolled in a Medicare Advantage Coordinated Care Plan also can receive their prescription drug coverage through the Medicare Advantage Prescription Drug (MA-PD) plan. The drugs are covered as long as the prescription is filled at one of the plan pharmacies or through the network's mail-order pharmacy.

Drugs purchased outside of the network can be obtained, but at an additional cost. For certain prescription drugs, additional requirements for coverage or limits on coverage are applied. Both brand-name drugs and generic drugs are included in the formulary, and the formulary is updated at least monthly.

For additional information on MA-PD plans, as related to the Medicare Prescription Drug Plan, Part D, see Part 2, Chapter 5, Section 5.9, "Medicare Prescription Drug Plan (Part D)."

5.8 Medicare Managed Care

Managed care plans serve Medicare beneficiaries through three types of contracts:

- risk
- cost
- health care prepayment plans (HCPPs)

All plans receive a monthly payment from the Medicare program.

In general, an individual is eligible to elect a Medicare Managed Care plan when each of the following requirements is met.

- The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan.
- The individual has not been medically determined to have ESRD prior to completing the enrollment form.
- The individual permanently resides in the service area of the Medicare Managed Care plan. A temporary move into the Medicare Managed Care plan's service area does not enable the individual to elect the Managed Care coverage.
- The individual or his/her legal representative has completed an enrollment election and it includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.
- The individual is fully informed of and agrees to abide by the rules of the Medicare Managed Care organization that were provided during the election process, and
- The individual makes the election during the election period.

The individual can still be covered under the spouse's health benefit plan; however, the rules for coordination will apply.

For more information on the Medicare Managed Care program, go to this website: www.cms.hhs.gov/manuals.

Go to the **CMS Transmittals** web page, and select the **Internet-Only Manuals Table of Contents** link. Then select publication **100-16**, *Medicare Managed Care Manual*, Chapter 2, "Enrollment and Disenrollment."

5.8.1 Risk Plans

Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries. Risk plans must provide all Medicare-covered services, and most plans offer additional services, such as prescription drugs and eyeglasses.

With the exception of emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. However, as of January 1, 1996, risk plans can provide an out-of-network option that, subject to certain conditions, allows beneficiaries to go to providers who are not part of the plan.

Since 1992, enrollment in risk plans has more than tripled to 5.3 million. Currently, 88 percent of Medicare beneficiaries in managed care are in risk plans. As of January 1998, risk plans made up 322 of the 427 managed care plans participating in Medicare.

5.8.2 Cost Plans

Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer.

Beneficiaries can also obtain Medicare-covered services outside the plan without limitation. When a beneficiary goes outside the plan, Medicare pays its traditional share of those costs and the beneficiary pays Medicare's coinsurance and deductibles.

5.8.3 Health Care Prepayment Plans (HCPPs)

Health Care Prepayment Plans (HCPPs) are paid in a similar manner as cost plans but only cover part of the Medicare benefit application. HCPPs do not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care), but some do arrange for services and may file Part A claims for their members.

5.9 Medicare Prescription Drug Plan (Part D)

As of January 1, 2006, Medicare offers a new prescription drug coverage, Part D. This prescription drug coverage can benefit American Indians and Alaska Natives (AI/AN) who pay for their prescriptions at retail pharmacies, as well as those who receive medications at no cost at IHS Tribal or Urban Indian programs (I/T/U).

Initial open enrollment began November 15, 2005 and runs for six months, ending May 15, 2006. In later years, open enrollment will run from November 15 to December 31, with enrollment effective January 1 of the following year. After beneficiaries choose a PDP, they will generally remain enrolled for the year.

Everyone with Medicare and Railroad Retirement is eligible for this coverage by joining an approved prescription drug plan (PDP) or a Medicare Advantage Drug Plan (MA-PD). All plans are required to offer basic drug coverage. However, drug plans and Medicare Advantage plans can separately offer enhanced coverage for an additional premium.

The program has an "opt-in" rule, which means that with limited exceptions, beneficiaries will need to make an affirmative statement to sign up for the drug beneficiary plan by filling out an enrollment form of an approved plan.

Generally, the two main options for how beneficiaries receive their drug benefit are:

- Those who wish to remain in traditional Medicare may elect to join a stand-alone prescription drug plan (PDP) that adds drug benefits to regular Medicare coverage.
- Those who wish to receive their entire medical and drug benefits from one source can join a Medicare Advantage (MA) plan, like an HMO, and chose an MA prescription drug plan (MA-PD plan), which will provide an integrated benefit covering their hospital, physician, and drug costs.

By participating in Medicare Part D, beneficiaries may help both themselves and their community.

- Individuals who pay for some or all medications at retail pharmacies may reduce their out-of-pocket costs paid to the retail pharmacy.
- Individuals who receive medications at no cost from an I/T/U site can benefit their community by enrolling in a drug plan; thus allowing the I/T/U site to bill the drug plan for reimbursement of part or all of the cost of the medications. The reimbursement funds can then be used to purchase other medications or services that benefit members of the community.

The categories of Medicare eligibles in the IHS system are:

Medicare A Only
Medicare B Only
Medicare A&B Only
Medicare A and Medicaid
Medicare B and Medicaid
Medicare A&B and Medicaid
Medicare A and Private Insurance (PI)
Medicare B and PI
Medicare A&B and PI
Medicaid/PI and Medicare A
Medicaid/PI and Medicare B
Medicaid/PI and Medicare A&B

A Summary of 3RD Party Resources report is located the RPMS Patient Registration Application.

The patient should be advised of his or her options to enroll in a PDP.

- Dual eligibles – those patients with Medicare and Medicaid – must choose a plan or they will be automatically enrolled in a plan. (IHS will not bill Medicaid but will bill the PDP).
- Patients currently on private insurance must review their plan to see if it is as good as the new Medicare benefit.
- Patients who do not have current drug coverage will need to choose a plan.

The drug plans charge members a monthly premium to participate in the plan. Individuals who qualify for both Medicare and Medicaid are eligible for a premium subsidy.

The patient may qualify for a

- Full premium subsidy, also known as Extra Help, if income is below 135 percent of the Federal Poverty Level (FPLL) with few assets
- Partial premium subsidy, if income is over 135 and under 150 percent of the FPL.

Either the local I/T/U site or the Social Security Administration will help individuals with the application process.

5.10 Railroad Retirement

The Railroad Retirement program is a Federal Insurance program similar to Social Security for workers in the railroad industry. The provisions of the Railroad Retirement Act provided for a system of coordination and financial exchange between the Railroad Retirement Program and the Social Security Program.

Like the Social Security program, the Railroad Retirement provides retirement, disability, and survivors' benefits under rules approximately the same as for Social Security. There is also a supplemental retirement annuity and, for some people, the possibility of collecting both Railroad Retirement and Social Security benefits.

Railroad Retirement number has either six or eight digits. Beneficiaries are indicated by a letter prefix.

Prefix	Description
A	Retired railroad worker (“Annuitant”)
MA	Spouse of an annuitant
WA	Widow or widower (of an annuitant) who is 60 or over
WCA	Widow of a child in her care, or child along (on annuitant)
PA	Parent of a deceased annuitant
JA	Survivor “joint annuitant”; an employee who is receiving a reduced annuity in order to guarantee payment to his widow
WD	Widow or widower (of an employee) who is 60 or over
WCD	Widow with a child in her care, or a child alone (of an employee)
PD	Parent of a deceased employee
H	Retired worker on a pension
MH	Spouse of a pensioner
WH	Widow or widower of pensioner
WCH	Widow with a child in her care or a child alone (of a pensioner)
PH	Parent of a deceased pensioner

5.11 Private Insurance

Private health insurance is a mechanism for people to protect themselves from the potentially extreme financial costs of medical care if they become severely ill, ensuring that they have access to health care when they need it. Private health insurance is provided primarily through benefit plans sponsored by employers. People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market.

Private health insurance provides health care benefits to an individual through a for-profit or not-for-profit insurance company or corporation. Private insurance covers almost every aspect of health care: hospital, surgical, medical, major medical, disability and mental health. A typical policy pays after he subscriber meets an initial calendar year deductible and a predetermined coinsurance amount.

Private health insurance is provided primarily by two different types of entities:

- State-licensed health insuring organizations
- Self-funded health benefit plans.

5.11.1 State-Licensed Health Insuring Organizations

The state-licensed health insuring organizations, as the name implies, are organized and regulated under state law. There are three primary types:

- **Commercial health Insurers**

  These are sometimes called indemnity insurers and are generally organized like stock companies or as mutual insurance companies. An example is Aetna.

- **Blue Cross and Blue Shield Plans**

  Many of these were organized as not-for-profit organizations under special state laws by state hospital and state medical associations. Blue Cross and Blue Shield Plans operate and are regulated in a similar manner to commercial insurers, although in a few states Blue Cross and Blue Shield plans continue to have special requirements to accept applicants for health insurance on a more lenient basis than is applied to other type of insurers.

- **Health Maintenance Organizations (HMOs)**

  These are usually licensed under special state laws that recognize that they tightly integrate health insurance with the provision of health care. HMOs operate as insurers (meaning they spread health care costs across the people enrolled in the HMO) and as health care providers (meaning they directly provider or arrange for the necessary health care for their enrollees). An example is Kaiser.

5.11.2 Self-Funded Employee Health Benefit Plans

Self-funded employee health benefit plans operate under Federal law and are health benefit arrangements sponsored by employers, employee organizations, or a combination of the two. Under a self-funded arrangement, the plan sponsor retains the responsibility to pay directly for health care services of the plan's participants.

In most cases, the sponsors of self-funded health plans contract with one or more third parties to administer the plans. The contracts are sometimes with entities that specialize in administering benefit plans, called third-party administrators. In other cases, sponsors contract with health insurers or HMOs for administrative services.

5.11.3 Typical Examples of Covered Services

- Office and clinic exams, procedures, and treatment
- In-hospital admissions and related services
- Emergency room care primarily related to a medical or accidental injury
- Surgical procedures in the office, clinic, hospital, or ambulatory surgery center
- Chiropractors
- OB care, including pre and post natal
- Lab, x-ray, and pharmacy
- Medical equipment and supplies
- Physical, Occupational, and Speech therapy
- Vision care
- Dental care
- Hospice care
- Defined list of preventive care

5.12 Managed Care

Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms, and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups, to enhance the quality and cost-effectiveness of health care.

Managed Care includes systems and techniques used to control the use and the cost of health care services. It also includes a review of medical necessity, incentives to use certain providers, and case management. Managed care techniques are most often practiced by organizations and professionals which assume risk for a defined population (e.g., health maintenance organizations), but this is not always the case.

Managed care has effectively formed a "go-between" brokerage or 3rd party arrangement by existing as the gatekeeper between payers and providers and patients.

Managed Care Organizations (MCOs) are entities that seek to manage health care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.

Examples of MCOs include

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Point of Service (POS)
- Exclusive Provider Organization (EPO)
- Provider Health Organization (PHO)
- Integrated Delivery System (IDS)
- Accountable Health Plan (AHP)
- Independent Practice Association (IPA)

Usually, a managed care organization is the entity which manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

A **Managed Care Plan** is a health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Managed care plans contract with providers to render health care services to members for a predetermined, discounted fee.

Under a Managed Care Plan, health coverage providers seek to influence the treatment decisions of health care providers through a variety of techniques, including financial incentives, development of treatment protocols, prior authorization of certain services, and dissemination of information on provider practice relative to norms or best practices.

Managed care health insurance is generally cheaper for employers because utilization requirements are stricter than private insurance plans. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them.

5.13 Dental Insurance

Medical insurance is designed primarily to cover the costs of diagnosing, treating, and curing serious illnesses. This process may involve a primary care physician and multiple specialists, a variety of test performed by doctors and laboratories, multiple procedures and masses of medications.

Dental insurance works differently. Most dental coverage is designed to ensure that the patient receives regular *preventative* care. High quality dental care rarely requires the complex, multiple resources often required by medical care. A thorough examination by the dentist and a set of x-rays are all it usually takes to diagnose a problem.

Dental care is provided by a general practitioner – dentist – and may require services of a dental specialist. Because most dental disease is preventable, dental benefit plans are structured to encourage patients to get the regular, routine care that are vital to preventing and diagnosing the onset of serious disease.

Most dental benefit plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. By placing an emphasis on prevention and by covering regular teeth cleaning and check-ups, millions of dollars are saved each year in dental care costs.

There are two types of dental compensation plans:

- **Indemnity Plans**

  An indemnity plan pays the dentist on a traditional fee-for-service basis. A monthly premium is paid by the patient or employer to the insurance carrier which directly reimburses the dentist for the services provided. Usually insurance companies pay between 50 percent and 80 percent of the dentist's fee for covered services.

  These plans often have a pre-determined deductible, a dollar amount which varies from plan to plan. Indemnity plans can limit the amount of services covered within a given year and can pay the dentist based on a variety of fee schedules.

- **Direct Reimbursement Plan**

  Under this self-funded plan, an employer or company sponsor pays for dental care with its own funds, rather than paying premiums to an insurance company. The plan may limit the amount of dollars an employee can spend on dental care within a given year, but often places no limit on services provided.

Regardless of the dental benefit plan, there are several different types of third-party insurers:

- **Dental Service Corporations**

  Dental service corporations are not-for-profit organizations that negotiate and administer contracts for dental care to individuals or specific groups. Examples include Delta Dental Plan and Blue Cross/blue Shield Plans.

- **Insurance Carriers**

  Insurance carriers are for-profit companies that underwrite the financial risk of and process payment claims for the dental services. Carriers contract with individuals or patient groups to offer a variety of dental benefit packages, including fee-for-service and managed care plans.

- **Self-Funded Insurers**

  Self-funded insurers are companies who use their own funds to underwrite the expense of providing dental care to their employees.

5.13.1 Examples of Typical Dental Coverages

Typical **preventive** dental treatments that are covered include:

- Initial oral and recall examinations
- Complete x-ray survey and bite-wing x-rays
- Prophylaxis or teeth cleaning
- Topical fluoride treatment

Typical **corrective** dental treatments covered, where most plans will cover 70 or 80 percent of the treatment, include:

- Restorative care
- Endodontics
- Oral surgery
- Periodontics
- Crowns

Prosthodontics – denture and bridge related services – are also included.

Dental insurance is designed to help get care at a reasonable cost. Because each person's oral health is different, costs can vary widely. To control dental cost, most plans will limit the amount of care you can receive in a given year. This is done by placing a dollar "cap" or limit on the amount of benefits you receive or by restricting the number or type of services that are covered. Some plans may specifically exclude certain services or treatments.

5.14 Pharmacy

Benefits for prescription drugs can be included in the medical insurance application or be provided by a separate Pharmacy Benefit Manager (PBM) through Aetna, Express Scripts, Medco, Pay Prescriptions, PCS, Blue Cross and Blue Shield, Cardinal or others.

Most of the drugs covered by the pharmacy insurers are listed on a preferred drug list or formulary, subject to applicable limits and conditions. Formularies include both brand-name and generic drugs that have been approved by the Food and Drug Administration (FDA) as safe and effective.

Most drugs listed on the preferred drug list are subject to manufacturer volume discount arrangements under which the applicable insurance company receives financial consideration. In addition, drugs on the formulary represent an important therapeutic advance or are clinically equivalent and possibly more cost-effective than other drugs not on the preferred drug list.

Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. The same rigorous FDA quality and safety reviews apply to generic and brand-name drugs; however, generic drugs may help lower the health care expenses for patients.

Several of the pharmacy insurers require pre-certification. It is designed to help encourage appropriate use of certain drugs in accordance with current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements.

Registration staff must remember to ask each patient if they have pharmacy insurance, and whether it is part of the coverage in the medical plan or is through a separate insurer.

5.15 CHAMPUS/TRICARE

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), now called TRICARE, is for members of the military and their families. TRICARE covers active duty and retired service members from any of the seven services: Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, or National Oceanic and Atmospheric Administration. In addition, spouses and unmarried children remain eligible for services under TRICARE even when the parents are divorced or remarry. Eligibility for children usually terminates at age 21 except if the child is a full time student or incapable of self support.

TRICARE also covers:

- Reservists and their dependents that have been called to active duty for 31 consecutive days
- Retired military service members and their spouses

Attaining Medicare eligibility does not mean beneficiaries lose eligibility for TRICARE., for example:

- Beneficiaries who become eligible for Medicare Part A on the basis of age and purchase Medicare Part B continue to be eligible for TRICARE, secondary to Medicare.
- Family members of active duty service members who are also eligible for Medicare for any reason retain eligibility for TRICARE whether or not they purchase Medicare Part B.
- Beneficiaries under 65 who are entitled to Medicare Part A because of disability or end stage renal disease and have purchased Medicare part B retain their eligibility for TRICARE until they turn 65, when they become only eligible for TRICARE for Life (a Medicare-wraparound coverage).

For more information, go to this website:

http://tricare.osd.mil.

5.16 Workman's (Worker's) Compensation

Workman's Compensation is an insurance offered by the state to employers, to cover risk-related work accidents and injuries. The laws regarding Workman's Compensation are state-specific and vary regarding coverage, reporting, and benefit waiting periods.

Employers are responsible for premiums and maintenance. The injured employee has a right to compensation for 100% of medical expenses.

Providers must provide a form to the Workman's Compensation office within a stipulated period of time. Each clinic or facility should check with their local office to understand the time requirement.

Workman's compensation is the primary coverage when there is an on-the-job injury and no other insurer is liable. The insurance company of the employer should be called to verify coverage. Notations should be made in the RPMS Patient Registration application, page 8, to indicate date, name, and approval.

When the carrier of the employee's work-related injury is notified, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury
- Authorize treatment for doctor's visits, physical therapy, prescription drugs, hospitalization, medical tests, prosthesis, and travel.

5.17 Third Party Liability

Liability cases involve traffic and other accidents where third-party insurance may cover a patient's treatment. In such cases the patient's insurer is responsible for covering the claim and later can seek reimbursement from the responsible party's insurer.

Patients may say someone else is responsible for their bill and that therefore their insurance information is not needed, but registration staff should explain that they must document every insurer that may be involved.

A provider is under no obligation to wait for appeal activity or legal action to be paid in liability cases. For more detailed information, see the Federal Medical Care Recovery Act (FMCRA) policy at this website:

http://www.ihs.gov/PublicInfo/Publications/IHSManual/Circulars/Circ06/Circ06_02/circ06_02.htm

5.18 Grant Programs

Research and grant dollars can be made available to the clinic to cover health-related research activities that would not have been available otherwise. As an example, the National Institute of Health (NIH) provides research grants and funding to programs that will reimburse the clinic for services, equipment, supplies, facility and administrative cost, publications, consultant fees, renovations, and other items.

5.19 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is the term is used by Medicare when Medicare is not responsible for paying first. Most private insurance companies refer to MSP as "Coordination of Benefits".

By Federal law, Medicare is secondary payor to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payor when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following means:

- An employer Group Health plan for working age beneficiaries
- A large Group Health Plan for disable beneficiaries
- Beneficiaries eligible for End State Renal Disease (ESRD)
- Liability/Automobile medical or no-fault insurance
- The Veterans Administration (VA)
- A Workers' Compensation (WC) plan
- The Federal Black Lung program

Any conditional primary payment(s) made by Medicare for services related to a third-party liability injury is subject to recovery.

The facility should submit the MSP information to the intermediary using condition and occurrence codes on the claim. After initial payment from the primary insurer, the clinic should submit a copy of the explanation of benefits (EOB) or rejection notice from the carrier with all appropriate MSP information to the designated carrier. Information related to the billing process and coordination of benefits is discussed further in *Part 4, Billing* of this manual.

For Trailblazers:

- Inpatient - an MSP needs to be obtained on every admission.
- Outpatient - an MSP needs to be obtained every 90 days.

If different Fiscal Intermediary is used, verify if there are different requirements for updating the MSP.

Data from the MSP form may be entered into the RPMS Patient Registration application and retrieved at a later time, if needed for auditing purposes.

For more information on MSP, go to this website:

http://www.cms.hhs.gov/COBGeneralInformation/

5.20 Tribal Self Insurance

Typically, a self-insurance plan involves payment of funds by a Tribe or Tribal organization into a liability pool. The Tribe or Tribal organization bears all the financial risk for the occurrence of a particular event, such as health care costs for tribal employees. When the particular event occurs, payment is made from the liability pool or from other tribal resources.

Under this type of arrangement, Section 206(f) of the Indian Health Care Improvement Act (INCIA), P.L. 94-437, 25U.S.C. 1621e(f) prohibits the IHS from seeking a right of recovery when the health services it has provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization. Consistent with Congressional intent not to burden Tribal resources, the agency has made a determination that tribal-funded, self-insured health plans are not to be considered alternate resources for purposes of the IHS payor of last resort rule. Thus, if a Tribal self-insurance plan exercises an exclusionary clause prohibiting payments to the IHS, then the IHS will not consider that healthcare plan an alternate resource. Subject to the availability of funds, the IHS will authorize CHS funds for payment of services otherwise covered by such a Tribal self-insurance plan, if the services are eligible for payment under the IHS regulations and no other alternate resources exist, subject to the availability of funds.

5.21 Verifying Third Party Insurance Coverage

5.21.1 Verifying Medicaid Insurance

A current copy of the state Medicaid card needs to be obtained from the patient and the information will be entered in the RPMS Patient Registration database. If there are discrepancies on the name and/or date of birth, the patient will need to correct these discrepancies with the state Medicaid office.

In addition, if the Medicaid card indicates an incorrect birth date or name, the name appearing on the card must be used until the state corrects the information on the Medicaid card.

If the discrepancy occurs on the facility records, the patient will need to furnish the required documentation to make the necessary changes/corrections.

To verify Medicaid, follow these steps:

1. Obtain copy of the patient's Medicaid card.

2. Speak to a representative at the state Medicaid program, or utilize on-line verification.

3. Identify the patient by providing his/her social security or Medicaid identification number to the representative.

4. Update eligibility information for date of service.

5. Enter patient data on **Page 4** and **Page 8** of the **RPMS Patient Registration** application.

5.21.2 Verifying Medicare Parts A and B Eligibility

A copy of the Medicare card needs to be obtained from the patient and the information will be entered in the **RPMS Patient Registration** application.

Any discrepancies must be corrected by the patient with the Social Security Office. If the discrepancy occurs in the facility's records, the patient will need to furnish the required documentation to make the necessary changes/corrections.

To verify Medicare A and B, follow these steps:

1. Obtain copy of the patient's Medicare card.

2. Speak to a representative at the Medicare Part A provider line.

3. Identify the patient by giving the Health Insurance Claim Number (HICN) - provide number, suffix, date of birth and gender - to the representative. For current HICNs, go to this website:

   http://www.cms.hhs.gov/Manuals/

   Go to the **CMS Transmittals** web page and select the **Internet-Only Manuals Table of Contents** link. The HIC number suffixes are listed in publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 2, "Hospital Insurance and Supplementary Medical Insurance," Section 50.2.

4. Eligibility is given at time of verification – information given is effective date, primary or secondary or coverage terminated.

5. Enter patient data on **Page 4** and **Page 8** of the **RPMS Patient Registration** application.

5.21.3 Verifying Private Insurance

For new patients to the facility or when insurance coverage has changed, the Registration staff needs to

- Obtain the insurance card.
- Xerox both sides of card.
- File the copy.

The Xeroxed copy of the insurance card will be verified with the insurance company (electronically or via a telephone call) by the Registration staff, Benefit Coordinator, or a Pre-Certification clerk. All verifications will be entered into the patient's file in the RPMS Patient Registration application.

To verify private insurance coverage, follow these steps:

1. Obtain copy of private insurance card.

2. Call or check on-line the private insurer listed on card and check **Page 8** of the **RPMS Patient Registration** application to ensure that the insurer's telephone number is the same.

3. Verify the following information:
   - policy number
   - person class code
   - group number
   - name
   - date of birth
   - billing address

4. Determine if there is a separate insurer for pharmacy, mental health, or dental.

5. Update the **Notes** page in the **RPMS Patient Registration** application.

6. Check the Patient Third Party Eligibility section in the RPMS Patient Registration application to verify accurate demographic and third party information.

7. Document all information in the patient's **Third Party Eligibility** information section of the **RPMS Patient Registration** application to include policyholder, billing address, telephone number, pre-certification number, filing limit, and benefit information.

8. Document the insurance representative's name and date of verification.

5.22 Prior Authorization Process

Prior Authorization, also called pre-certification or pre-authorization, is the process by which the insurer evaluates the medical necessity of the proposed hospital stay and certain outpatient services, the number of days that are required to treat the condition, services for mental conditions or substance abuse, and even certain drugs.

The Prior Authorization process involves the hospital or provider contacting the plan, usually within 24 hours prior to admission. After providing the patient's name, identification number, birth date, reason for hospitalization, name and phone number of provider, and number of planned days in the hospital, the insurer will approve the days of confinement for the care of the patient's condition. Written confirmation usually follows.

For emergency admissions, the provider or hospital must call the insurer within two business days following the day of admission, even if the patient has been discharged from the hospital.

Not all insurers require Prior Authorization; however, the clinic and/or Billing should be aware of those that do require this process. If Prior Authorization is required but not performed by the clinic, the admission or the outpatient services will not be reimbursed.

Note: For approving a stay, extending an admission for additional days, or approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.

5.22.1 Inpatient Prior Authorization Procedure

Note: Prior authorization for weekends and holidays is completed the next business day. Follow each payor's criteria.

The Admission and Discharge sheet generated from the RPMS Admission/Discharge/Transfer (ADT) application will be used to verify all inpatient third-party information. If data was obtained during the pre-op visit, this information will be found in the patient's file of RPMS.

1. An admission/discharge summary report will be printed-out and used as a guide to check all inpatient admissions to determine whether the patient has any alternate resources. If the patient has any alternate resources, verification of coverage will be completed and pre-authorization will also be obtained, if required.

2. The verification/admit clerk will use the following information when calling in for verification and authorization:
   - Admission date
   - Admission time
   - Admitting diagnosis (ICD9)
   - Admitting physician (facility address, facility telephone and physician specialty)
   - Patient Name
   - Date of birth
   - Name of insurance policy holder and policy number
   - Name of Third Party Private insurance
   - Name of Facility/Address/Telephone number (Federal Tax Identification Number)

3. The verification/admit clerk will update all pertinent information in the **Third Party Eligibility** section of the **RPMS Patient Registration** application.

4. The Utilization Review personnel will be notified. The authorization number is utilized for billing purposes once the patient is discharged from the facility.

5. The Utilization Review Case Management personnel will receive notification via their assigned pager regarding the identified patient as having medical health insurance.

6. The UR personnel will document such information as authorization number, review nurse, inpatient unit, treatment plan medications, and other related information on an established worksheet.

   The facility may want to establish a worksheet for recording this information.

Note: For approving a stay, extending an admission for additional days, or approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.

5.22.2 Outpatient Prior Authorization Procedure

All outpatient cases will be verified and authorized on the pre-operative visit, with the exception of emergency cases.

1. The verification/admit clerk will use the following information when calling in for verification and authorization:
   - Preoperative date
   - Day surgery date
   - Diagnosis (ICD-9)
   - Surgical procedures (CPT)
   - Other services, such as rehab, PT with date range of services
   - Name of physician and specialty
   - Patient Name
   - Date of Birth
   - Name of insurance policy holder and policy number, copied front and back
   - Name of Third Party Private insurance
   - Name of facility, address, telephone number (Federal Tax Identification Number)

   The verification/admit clerk will document this information which will be routed to the Utilization Review personnel for follow up. The authorization number is utilized for billing purpose once the patient is discharged from the facility.

2. The verification/admit clerk will update all pertinent information in the **Third Party Eligibility** section of the **RPMS Patient Registration** application.

3. The Utilization Review Case Management personnel will receive notification regarding the identified patient as having medical health insurance. The information such as an authorization number, review, nurse, past medical history, treatment plan, and medications should be recorded on a form.

Note: For approving an outpatient clinic visit, the pre-certification number can be documented in the RPMS Patient Registration application.

5.23 Patient Referral to the Benefit Coordinator

The Registration staff needs to have a defined process in place for referring patients to the Patient Benefit Coordinator. Details of this process are described in Part 2, Chapter 7, "Benefit Coordinator." In addition, Registration staff needs to understand who potentially may qualify for alternate resources and make sure these individuals are appropriately referred to, as well as, meet the Benefit Coordinator.

Patients can be referred to the Patient Benefit Coordinator using the RPMS Patient Registration application, which notifies the Benefit Coordinator. The information provided will include the patient's name and medical record number